tage of uniform applicability by researchers, they are the criteria for adult depression. Empirical research is necessary to determine how these criteria might vary with age and development.

Some researchers emphasize the difficulties involved in defining depression as a clinical phenomenon, the diagnosis of which can be based on the observation of a group of symptoms or an inference regarding some presumed underlying process. Nonetheless, consistent criteria, even with imperfections, are a considerable advantage to clinicians and researchers.

Biologic research is helping to refine criteria as it defines different subgroups of childhood depression. In one study of 18 dysphoric children aged 6 to 12 years, using the dexamethasone-suppression test, nine children were found to meet diagnostic criteria for a major depressive disorder, and eight of the nine met the diagnostic criteria for endogenous depression. Five of the nine depressed children had abnormal dexamethasone suppression, failing to have suppressed 4 PM cortisol concentrations the day after an 11-PM dose (0.5 mg) of dexamethasone. The results parallel the research completed in adults who have endogenous depression, suggesting that this illness is not rare in childhood and that it is clinically and neuroendocrinologically similar to the adult disorder. This test may have considerable clinical applicability. It is frequently used in adults with depressive symptomatology, and similar use can be anticipated for children.

A variety of neuroendocrine studies have been completed that validate the existence of childhood depression and confirm its similarity to adult depression. Some of these studies are linked directly to treatment, such as a study of imipramine response in children. Response to the antidepressant is clearly linked to the plasma concentration of the drug. Steady-state plasma concentrations of more than 150 ng per ml are associated with clinical response, and optimal responses were obtained at plasma concentrations above 200 ng per ml. Dose does not necessarily predict plasma concentration, so levels have to be monitored carefully, as with adults. Researchers have studied plasma levels of growth hormone at 15-minute intervals after the injection of insulin (which induces hypoglycemia), comparing the growth hormone levels of children meeting the research diagnostic criteria for endogenous depression, nonendogenous depression and a group with neurotic emotional disorder. Of the endogenous group, 90 percent were reported to have a peak growth hormone secretion in the first hour of less than 4.0 ng per ml. Virtually 100 percent of the neurotic group had levels above 4 ng per ml. A small group (10 percent to 15 percent) of children who have depression have an increased secretion of cortisol in a 24-hour period. Another study has found that the older a child, the more likely he or she will have this pattern.

These findings suggest a similarity to major affective disorders in adults but also imply age-related biologic effects. These findings further support the use of diagnostic criteria and suggest that there might be developmental effects. This is an area that will continue to be the subject of considerable investigation.

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IRVING PHILIPS, MD

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Hysteria, Behavior and Physical Symptoms

THE TERM HYSTERIA has previously been used as a label for abnormal preoccupation with physical functions and complaints, conversion symptoms, amnesia and personality disorders. However, the current definitions published by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Ed* have reorganized this broad spectrum of symptoms into more cohesive categories and thus should be reviewed by practitioners.

These newer definitions basically relabel and more clearly delineate previously recognized aspects of the diagnoses of hysteria. The one exception is hypochondriasis, which, as before, is an independent diagnosis characterized by an unrealistic interpretation of physical signs or sensations, often leading to preoccupation with the fear or belief in an actual serious physical disease.

Examples of the relabeling process can be seen in both the conversion disorder, which continues in the new diagnostic standards without the previous modifier "hysterical," and in the somatization disorder, previously described as Briquet's syndrome. The actual diagnostic criteria of both remain relatively unchanged. A conversion disorder is characterized by a loss or alteration in physical functioning, suggesting a physical disorder, but in reality is an expression of psychologic problems. In persons who have conversion disorders, difficulties usually develop in the voluntary nervous system or senses, frequently based on a precipitating event. Secondary gains are also common observations, that is, a person unable to obtain support from family and friends begins receiving reinforcement because of his or her "illness." Somatization disorders, as described in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Ed,* emphasize current, multiple somatic symptoms of years' duration, leading to frequent medical consultations that never result in adequate physical explanation of the symptoms.

An example of reorganization and updated diagnostic

criteria is evidenced by the disorder previously labeled hysterical personality and now incorporated in the current definition of histrionic personality. Persons suffering from hysterical or histrionic personality disorders show features of dramatic, intensely expressed behavior, emotional lability, exhibitionism, craving for activity and excitement, sexual problems, dependency, vanity and superficial manipulative interpersonal relations. The disorder often presents clinically in the form of verifiable physical symptoms that develop as a consequence of injury, illness or aging. However, patterns frequently emerge involving excessive complaints of the intensity of the disability, as well as dependent relationships (based on financial or emotional rewards) encouraging an unconscious motivation to continue the disability. Often drug or alcohol abuse is an associated symptom.

In the past, under the heading "hysterical personality," these symptoms were almost exclusively diagnosed in women and, indeed, were considered to be a distortion of the "usual" feminine characteristics. Recent clinical observation, however, incorporated into the new criteria for histrionic personality, has concluded the disorder exists in men as well as women and may be manifested by either effeminate passive qualities often seen in homosexual men, or in the newly recognized group of "macho" men, who show the same basic difficulties of dramatic, reactive, expressive, exhibitionistic, aggressive and manipulative behavior. Because this latter group often shows these behaviors with exaggerated stereotypes of masculinity (for example, dress, tattoos, fights, verbal abusiveness and motorcycles or automobiles), the critical characteristic is now considered a distortion of gender behavior with an exaggeration of *either* masculine or feminine characteristics.

The treatment of choice for the various diagnoses continues to be early psychotherapeutic intervention and a return to normal activities, though medications may be helpful for short-term or focal use in relieving symptoms of anxiety or depression. JOE P. TUPIN, MD

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The Newer Antidepressants

SEVERAL NEW ANTIDEPRESSANTS (maprotiline hydrochloride, trazodone hydrochloride, trimipramine maleate and amoxapine) have been marketed in the United States during the past few years. An additional 25 drugs are either currently marketed outside the United States as antidepressants or are in various stages of testing.

Claims of rapid onset of action for some of the newer antidepressants may be true for some patients, but to date none of the newer agents have consistently shown shorter response times than their older counterparts. Some of the new agents may be safer in overdose attempts, but unfortunately adequate assessment of a safety profile of a new antidepressant must await the evaluation of overdosing by many different persons.

It is not clear whether the newer antidepressants have distinctively fewer side effects than some of the older agents. However, particular side effects—for example, anticholinergic—may be lessened with some of the new antidepressants. A complete profile of the side effects for a particular drug (for example, tardive dyskinesia from long-term use of major tranquilizers) may take several years to emerge.

Several studies suggest that for a particular patient one antidepressant may be substantially more effective than another. The newer antidepressants may conceivably afford selected patients therapeutic benefits not available with older agents.

Following are some of the claimed advantages and possible disadvantages of the newly marketed antidepressants. Maprotiline possibly has a more rapid onset, lower cardiovascular toxicity and lower anticholinergic side effects, but also there is the increased possibility of skin rashes; trazodone possibly has a more rapid onset, lower cardiovascular toxicity and lower anticholinergic side effects, but also an increase in drowsiness; trimipramine has actions similar to older tricyclics, and amoxapine possibly has a more rapid onset but also some neuroleptic activity. MICHAEL J. GARVEY, MD

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Underdiagnosis of Physical Causes of Psychiatric Symptoms

PSYCHIATRIC SYNDROMES resembling depression, anxiety, mania and even schizophrenia often result from undiagnosed organic conditions. One study of more than 2,000 psychiatric clinic patients reported major medical illness in 43 percent of the sample. Almost half of these illnesses had not been diagnosed by the referral source (nonpsychiatric physicians had failed to diagnose 32 percent of these major medical illnesses, psychiatrists 48 percent and social agencies 83 percent). In almost 8 percent of cases, the medical illness was the cause of the patient's psychiatric signs and symptoms. Other studies have produced similar findings. Despite previous medical examinations, about 5 percent of psychiatric inpatients suffer from undiagnosed medical diseases causing their psychiatric disorders. In all likelihood organic causes also underlie a portion of the psychiatric symptomatology that goes unrecognized in medical inpatient and outpatient practices.

Of previously unrecognized organic illnesses, 90